Southen Connecticut State University
Department of Communication Disorders
501 Crescent Street
Davis Hall B-012
New Haven, CT 06515
(203) 392-5955

Application for Clinical Services from:

☐ Center for Communication Disorders ☐ Access Network ☐ Southern CT Audiology Services

Applicant's Relationship with SCSU: ☐ Student __☐ Faculty __☐ Staff ☐ None

Name of Applicant ______________________________

Date of Birth ______________ Age __________ Gender ______________

Address ______________________________
Number Street

____
City State Zip

Phone(s): Home ______________________ Work ______________

Email: ______________________________

Parent(s) / Guardian (if under 18): ______________________________

Relationship: ______________________________

If adult, name of contact person, if appropriate: ______________________________

Relationship: ______________________ Phone: ______________

Emergency contact: Name ______________ Relationship ______________
Phone ______________

Doctor's Name ______________________ Phone ______________
Doctor's Address ______________________________

Name of Person Completing this Application ______________________________
Relationship to Applicant ______________________________

If applicant is a child, they attend: ☐ Play Group ☐ Day Care ☐ Preschool
☐ Elementary School ☐ Jr./High School Grade: _________ ☐ N/A
Name of School/Program: ____
Address: ____ Phone: ________________

If applicant is an adult, Occupation: ____
Place of Employment: ____
Address: ____

Please share any information that you believe will help us to evaluate the applicant's communication skills.

Who referred the applicant to the Center for Communication Disorders?
Name ______________________________________ Relationship ______________________________

What other doctors, teachers, therapists or schools have evaluated the applicant for the problem? (Use back of Page 3, if necessary.)

Date	Name	Title

List any medications taken by applicant:

Name of Medication	Purpose of the Medication

List applicant's allergies if any:

Check all that apply: the applicant:

- ☐ walks without assistance
- ☐ walks with cane or walker
- ☐ uses a wheelchair or stroller
- ☐ wears glasses/contacts
- ☐ wears hearing aid(s)
- ☐ uses a communication device
- ☐ uses sign language

What languages are spoken in the home?

Check all conditions that the applicant has ever had:

- ☐ Hypertension
- ☐ Heart Problems
- ☐ Diabetes
- ☐ Frequent Dizziness
- ☐ Frequent Ear Infections
- ☐ Seizures
- ☐ High Fevers
- ☐ Difficulty Concentrating
- ☐ Difficulty Sitting Still

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AUTHORIZATION FOR USE OF CLINICAL MATERIALS

Southern Connecticut State University's clinical service programs (***Center for Communication Disorders; Access Network; Southern Connecticut Audiology Services)*** provide clinical and research opportunities for students training to become Speech-Language Pathologists by providing audiology or speech-language services to members of the community. We are a teaching facility, and information acquired during evaluation and/or treatment sessions will be used for teaching and/or research purposes. Every attempt is made to maintain the confidentiality of the clients involved.

In consideration of the above, regarding the educational and scientific use of clinical materials pertaining to ________________________________:

	Client's or Guardian's Initials
I give permission s to make customary and confidential use of any obtained clinical materials.	_______________
I consent to audio/video recordings of services for use in evaluation and treatment.	_______________
I give permission for the Department of Communication Disorders to keep and play copies of audio/video recordings made during evaluation or treatment sessions for teaching purposes.	_______________
I give permission for faculty, staff and students to observe evaluation and/or treatment sessions.	_______________
I give permission to the Department of Communication Disorders to communicate with me regarding my services by telephone, email, text, postal mail, or fax, as requested.	_______________
I give permission to send reports regarding services I received Through the Department of Communication Disorders to parties ***for whom I have provided a written release of information*** in person or by fax, text, email or postal mail, as requested.	_______________

Signed: ____ Date: _____________

Relationship to client: ____________________________________

Staff Signature: ____ Date: _____________